Statement by Ilene Stein, Federal Policy Director
Medicare Rights Center
on
Protecting Medicare with Improvements to the Secondary Payer Regime
Before the
House of Representatives
Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
June 22, 2011 at 10 a.m.
2125 Rayburn House Office Building
Washington, DC

Good morning, Chairman Stearns, Ranking Member DeGette, and other distinguished members of the sub-committee. I thank you for the opportunity to testify today about the current secondary payer program and the difficulties Medicare beneficiaries face when navigating this system.

I am Ilene Stein, federal policy director for the Medicare Rights Center (Medicare Rights). Medicare Rights is a national, nonprofit consumer service organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Last year, we assisted more than 14,000 Medicare beneficiaries and nearly 4,000 health care professionals through our national helpline. Additionally, Medicare Rights' online educational tool Medicare Interactive received 420,000 site visits. Through our advice and counseling, we were able to assist beneficiaries in understanding their Medicare coverage and their rights within the Medicare program, and in accessing needed prescriptions and health services. These calls inform our public policy efforts and allow Medicare Rights to bring the voice of Medicare beneficiaries to the national conversation about Medicare.

Like all health insurers, Medicare has established rules about when it will make primary insurance payments. The purpose of the Medicare Secondary Payer policy is to ensure that Medicare does not make primary insurance payments for services covered by another payer or insurer. For example, if an individual with Medicare is in an accident, it may be determined through settlement or other legal proceedings that the insurance of the party

at fault is the primary payer for medical services related to incident. Medicare will not, and should not, pay for those services. If Medicare has paid for services during the pendency of the settlement, the program is entitled to recover these costs. Medicare contracts with a private entity, the Medicare Secondary Payer Recovery Contractor (MSPRC), to determine the claims for which Medicare is secondary payer, the amounts owed to Medicare, which party is responsible for payment, and to process collections.

For the health and integrity of both the Medicare trust fund and the Medicare program, a robust secondary payer regime is necessary. Therefore, we support the program's right to collect payment for services for which the program should not be paying. However, the current system is flawed in both policy and implementation. The results can be devastating for Medicare beneficiaries. Not only do individuals receive demands from Medicare for large amounts of money that, in some cases, they do not owe and/or cannot pay, but in certain situations, Medicare will cease coverage because cases were improperly closed by MSPRC.

Though not all-inclusive nor mutually exclusive, the problems we identified with the secondary payer process fall into five categories: untimely collection of Medicare's share of settlements; MSPRC calculation errors; difficulty obtaining information about the secondary payer case from MSPRC; difficulty resolving cases with MSPRC; and problems with notices, appeals, and the hardship waiver process.

I. Untimely collection of Medicare's share of settlements

Currently, there is no established timeframe by which Medicare must tell individuals what they owe if they have settled in a liability case. We know that beneficiaries who contact Medicare before a settlement is finalized experience long wait times before they receive an estimate of Medicare's costs, causing undue delay and injecting uncertainty into the settlement process. If a beneficiary settles without knowing the Medicare costs, he or she may end up owing a sizeable portion of the settlement to Medicare. We have seen cases where after a settlement is reached, MSPRC contacts a beneficiary and

recoups almost the full amount of a settlement. Moreover, in other cases, because the beneficiary is unaware that Medicare has the right to recoup money, and because in many cases MSPRC reaches out to the beneficiary years after a case is settled, it is likely that the settlement is already partially or fully spent. This creates a precarious financial situation for the beneficiary.

Unfortunately, for many beneficiaries who call our helpline, Medicare was not contacted at the time of settlement. Currently, the burden lies with the beneficiary to notify Medicare of settlement, but unless he or she is represented by an attorney knowledgeable about the program, they have no way to know this obligation exists. For this reason, we appreciate new requirements that would create obligations for other, more empowered parties to contact Medicare, with notice to the beneficiary and his or her representative.

II. MSPRC calculation errors

MSPRC often miscalculates the amount that Medicare is owed. Frequently, callers to our helpline receive notices from MSPRC requesting repayment for treatments that are unrelated to injuries associated with a previous accident. This is because the contractor does not properly segregate claims related to an accident from other claims completely unrelated to those past injuries. In these cases, not only can MSPRC send a demand letter to a beneficiary to recoup past coverage, but it may prospectively deny coverage for care or even begin to automatically deduct money from Social Security checks. Moreover, as is the case with the MSPRC notice for settlements, these demands, reductions and terminations occur years after the accident took place and, in some cases, years after the MSPRC case was supposedly closed.

An illustrative example comes from a Medicare beneficiary from Florida who called our helpline this year:

> *Ms. B and her husband were in an auto accident in August 2000 in which they sustained no injuries, but were taken to the hospital as a precautionary measure*

and received X-rays at minimal cost. Despite the low cost of the hospital visit, Medicare is seeking recovery of about $26,000 for payments made for treatments of cancer, rheumatoid arthritis, and other injuries and diseases that are completely unrelated to the accident.

III. Difficulty obtaining information about the secondary payer case from MSPRC

If beneficiaries have questions about a notice received because it requires payment for services unrelated to a past accident or references an accident that occurred several years ago, or if they received no notice at all but are unable to access any Medicare coverage, it is extremely difficult to obtain information pertinent to their cases. First, it is our experience that wait times to speak with a customer service representative (CSR) often exceed 30 minutes and can exceed an hour. Of course, this assumes the beneficiary is able to get through at all, since the phone line is sometimes busy. Wait times and unanswered lines discourage beneficiaries from obtaining necessary information and resolving their case.

Second, MSPRC representatives routinely provide incomplete or inaccurate information, which necessitates further phone calls. Because Medicare beneficiaries are not assigned an individual caseworker, each time a beneficiary contacts MSPRC he or she must initiate a whole new discussion of the case issues. We suspect that MSPRC case logs are lacking because information that should have been recorded in earlier calls does not appear on file when subsequent calls are made. When beneficiaries have asked to speak with a supervisor, their requests have been refused.

IV. Difficulty resolving cases with MSPRC

If beneficiaries are finally able to reach a knowledgeable customer service representative, many times they find the source of the issue is that MSPRC did not properly close a case. As a result, though the insurance company has closed the case, the Medicare system

believes that Medicare is still a secondary payer. Consequently, Medicare stops paying for services.

Such a serious matter should be resolved quickly. But in order to close a case, MSPRC requires that the beneficiary obtain additional documentation that the case was closed by the insurer who covered accident-related costs, and that medical records demonstrate claims in dispute are unrelated to previous accidents or incidents. To our knowledge, this requirement is not detailed in any written notice.

A client story from New York illustrates the difficulties beneficiaries face simply trying to close cases:

> *Ms. B was in a car accident, and at the time of the accident her automobile insurance paid for all related hospital and physician bills. Several years after the accident, she received a notice from MSPRC indicating that she owed money for recent treatments unrelated to those that resulted from the car accident. When she was able to reach an MSPRC representative, she was told that in order to close the case in MSPRC's system she must obtain a letter from her auto insurance company certifying that they had in fact paid primary on medical claims related to the accident. This was difficult to obtain because the accident had occurred several years earlier. However, after much effort Ms. B was able to obtain the letter. She submitted the letter MSPRC three separate times, but the case remained open. During this time, Ms. B continued to receive demand letters. After multiple calls to MSPRC, Ms. B was told by a customer service representative that she needed to obtain documentation from the hospital where she was treated for injuries related to the accident demonstrating what services she received and for what conditions. Again, given that the accident occurred several years ago, these records were difficult to obtain. Even after this documentation was promptly sent by the hospital to the contractor, the case remained open for several months.*

V. Problems with notices, appeals, and the hardship waiver process

Finally, notices sent to consumers by MSPRC are incomplete, not written in a consumer-friendly manner, and lack important information about the appeals and the hardship waiver process. While the letter mentions an appeal right, it does not thoroughly spell out the appeals process. Additionally, the notice lacks information about the availability and process for requesting a financial hardship waiver.

If beneficiaries feel that they are unable to pay the amount owed to Medicare, waivers are allowed in very limited and specific circumstances. Poverty alone is not a sufficient basis for granting a waiver. In addition, beneficiaries who request waivers are required to provide extensive documentation about both their case and their income and assets. If a waiver is denied, there is no right to an appeal. Overly restrictive and arbitrary eligibility requirements for waivers, requirements for such extensive and specific documentation, and limited appeals rights may explain why beneficiaries who call our helpline are reluctant to request waivers and why those who do are often denied. This chips away at the financial security of people living on very limited incomes, and threatens their access to needed health services. Nearly half of Medicare households have incomes below $22,000 per year. Despite this sobering statistic, rates of appeals and hardship waiver requests are surprisingly low.

Recommendations

Contractor error and poor program administration can be fixed administratively and do not require Congressional intervention. Medicare Rights and the Center for Medicare Advocacy have requested a meeting with the Centers for Medicare & Medicaid Services (CMS) to discuss these obstacles and potential solutions. Other obstacles, however, are rooted in the statutory and regulatory framework of the secondary payer regime and may require statutory changes.

There are several steps that can be taken legislatively or administratively that would help solve many of the problems that beneficiaries encounter:

- Ideally, as soon as incidents are reported to Medicare, Medicare would then provide the insurer and the beneficiary with an estimate of the conditional payments made by Medicare for treatment related to the injury, as well as an estimate of future treatment.
    - There is precedent for Medicare pre-determining the program's share of costs in the context of worker's compensation. In those cases, Workers' Compensation Medicare Set-aside Arrangements (WCMSAs) can be formulated. These arrangements allow a portion of the worker's compensation settlement to be used for future medical and prescription drug expenses related to the on-the-job injury.
- Medicare collection practices should ensure timely recovery. Medicare Secondary Payer claims should not be initiated more than two years after the settlement has been made. This would also help to ensure that in settlement negotiations and legal proceedings all parties are able to consider Medicare's claim.
- CMS and its contractors should be required to improve the notices provided to consumers. Specifically, the notices' language must be more consumer-friendly, and the notices should include more detailed information about appeal and hardship waiver rights and processes.
- MSPRC or any future contractor should be required to maintain a transparent, easy-to-use process through which beneficiaries and their representatives can obtain information about their cases. This means both ensuring shorter call times and, more importantly, assigning a specific staff member to cases who can be reached directly.
- The hardship waiver process should be made more transparent and less burdensome on consumers. The rules should be revised to waive Medicare Secondary Payer recovery up to a reasonable amount for low-income consumers in all circumstances.

- CMS and its contractor should develop a better process for separating claims that are and are not related to an accident. CMS and the contractor should also be required to make decisions expediently when beneficiaries dispute the inclusion of claims because they do not believe they relate to an accident.

It is imperative that any changes to the law do not require beneficiaries to forfeit rights to request a hardship waiver or appeal.

Out of respect for the committee's time, I have just given an overview of the issues that people with Medicare face in the context of Medicare Secondary Payer. Thank you again for the opportunity to testify today—I'd be happy to respond to any questions from the committee.